WMIP Questions and/or Concerns
REPORT 2, June 2, 2004

Submitted by Snohomish County April 21, 2004

5. What are the WMIP disincentives for overuse of state and local hospitals?

Answer: There is no financial disincentive for overuse of state and local hospitals; however, contractor performance will be closely monitored to avoid overuse of hospital beds. The WMIP plan must develop a good knowledge of diversion resources and there must be coordination between the plan and mental health providers to ensure appropriate placement of enrollees. The plan will be required to develop an internal tracking process to ensure enrollees receive services in the most appropriate, least restrictive setting available.

6. How will discharge planning from the state hospitals be coordinated?

Answer: There are a number of models that will be shared with the WMIP plan as "best practice" for discharge planning. The WMIP contractor will be required to stay involved with clients when they are admitted to hospital settings.

8. Who is responsible for residential services?

Answer: In general, those currently responsible for residential services will continue to have responsibility after initial implementation of the WMIP. It is DSHS' intention to incorporate responsibility for residential services with the WMIP contractor in July 2005.

10. How will WMIP protect against over use of crisis services?

Answer: The contracted health plan will be responsible for initial screening upon enrollment in the program and for providing care coordination services. In addition, client will have a guaranteed medical home and a 24 hour number from the WMIP health plan, which should also reduce the number of calls being made to crisis services. The contractor will be required to work together with the RSN, crisis system, and community providers to develop a protocol that ensure coordination.

13. Since DSHS states that WMIP integrates funding and services, how will Mental Health Services be integrated?

Answer: Molina Healthcare will use Care Coordination Teams to integrate services. Each team will consist of a Care Coordination Specialist, an RN Care Manager, a Social Worker and a Catastrophic Case Management nurse. These teams will have backup from Molina Healthcare physicians, pharmacists, and mental health professionals.

The Care Coordination teams will be responsible to develop integrated care plans incorporating medical, mental health and/or chemical dependency needs. The care plans will address WMIP benefits as well as services covered by other agencies.

18. DSHS states there will be only minimal financial impact on the RSN. What does minimal mean specifically?

Answer: DSHS has limited the services to be covered by the WMIP contractor, thereby leaving the majority of the RSN capitation rate with the RSN. In addition, according to DSHS' actuary, the mental health capitation rates are built with an assumption of 23% administrative overhead. When WMIP rates were built, they assumed a more typical 15% medical administrative overhead rate. So, the RSN will not only keep the funding associated with the direct services and administrative overhead they are still responsible to provide, they will also keep a portion of the administrative overhead for services provided by the WMIP contractor. Also see the answer to the last question (63) on projected financial impact using different models of enrollment.

19. DSHS states they are considering methods to guard against cost shifting, and that they will develop methods to guard against cost shifting in either direction.

a. What methods have been developed?

Answer: DSHS will review encounter data to evaluate utilization of services across systems of care. If a change in the pattern of the use of services in Snohomish County occurs, the cause will be analyzed. A cause which can be detected fairly early is that enrollment into WMIP is not distributed across the population in terms of historical use of services. We will use risk adjusted rates to account for any unexpected differences in the pattern of enrollment, and may apply retroactive risk adjustment to account for mental health selection bias. Another cause of differences in service use could be "cost shifting", which means the same people use a different set of services compared to historical use. This can also be monitored retroactively, but it will take time for claims data to mature in order to detect this shift. In general, DSHS allows one year for complete claims submission.

Ways to guard against any shifting away from preventive care and toward acute care include short term measures such as monitoring client and provider complaints, and long term measures, such as collecting HEDIS measures and other indicators of quality and access to care. Annual on-site monitoring would include an analysis of complaints, grievances, and appeals. If DSHS detects problems in this area attributable to either the RSN or the WMIP contractor, corrective action will be taken.

b. Reporting times to RSN on cost shifting?

Answer: Reports on cost-shifting will be provided to the Snohomish County Advisory Committee within two years of the program start date.

20. DSHS states that under managed care contracts for all Medicaid clients, they are required to give enrollees written information on their rights and responsibilities. How will the WMIP provider provide Ombuds services and QRT services? This is part of the WAC.

Answer: The WMIP bidder plans to contract with an ombuds person who will work with enrollees. In addition, under BBA rules for all managed care systems, the contractor will be required to conduct surveys and other quality improvement activities similar to the QRT. The Advisory Board may also be able to surface issues through anecdotal reports or by creating an early warning system.

22. DSHS states that the impact to North Sound in terms of dollars is less than the projected increase of funds in the upcoming biennium. Please provide data and calculations to support your statement.

Answer: Our original response to this question was based on the projected 2005 rate increase. However, due to changes in the waiver that covers RSN contracts, the 2005 mental health rates are currently being recalculated. Since they have not been approved by the Centers for Medicare and Medicaid Services (CMS), we do not know how the above projections will relate to the final approved rates. See also the response to question 63 on projected changes to funding from the RSN to WMIP contractor. Our best guess is that in the absence of selection bias, the impact will be 0.

23. How or will the WMIP contractors be paid for their start-up costs? When will the payments to the RSN begin decreasing? What is the plan for switching funding from the RSN to the WMIP?

Answer: The WMIP contractor will not receive start-up costs. Payments to the RSN will decrease with enrollment of the first clients. The funds will be reduced from the monthly capitation paid to the RSN. DSHS will monitor opt-outs and funds will be allocated accordingly.

26. What will be the process for handling disagreements/disputes between the RSN, mental health providers and the MCO about the need for inpatient care and eligibility for outpatient care?

Answer: A process currently exists to resolve disputes regarding mental health services between MAA's Healthy Options program and the Mental Health Division. We anticipate expanding and tailoring that process for WMIP dispute resolution. This process will also include the WMIP plan and providers.

27. Western State Hospital beds. A February 2004 Q&A from DSHS indicates these will not be affected, as WMIP plans will not be responsible for state hospital admissions. How will liability be assigned if penalties are assessed for an overuse of bed days at Western State Hospital? How will the managed care organization make use of in-patient mental health hospital resources; how will involuntary hospitalization affect the limit the State imposed to our county to use this resource?

Answer: Most funding for State Hospital beds comes out of state-only funds so cannot be included in a Medicaid program. The WMIP program must develop a mechanism to coordinate with the mental health system to authorize appropriate hospitalizations; for

example, the WMIP care coordination team will be involved in discharge planning and follow-up services.

28. If the RSN is responsible for providing all crisis services, what structure will be in place to ensure that the MCO provides appropriate follow-up care, so that the consumer is not repeatedly coming back through the crisis and hospital (inpatient) systems?

Answer: The care coordination component of the WMIP has been stressed as an important part of ensuring that follow-up care occurs so that enrollees are stabilized and do not continue to cycle through the crisis and inpatient systems. Additional access to regular medical and mental health services will help ensure WMIP enrollees rely on the crisis system less. The contractor will be required to establish relationships and protocols with the current system, so that for example, clients who need outpatient appointments within a week of discharge will be able to access them.

32. DSHS published mental health PMPM rates on Table C-5 dated (12/30/03). The original proposal had a list of required mental health services to be provided. Then DSHS published new PMPM rates on Table C-5 dated (3/15/04). When the rates were changed we are making an assumption that the services to be provided will also change. Please publish the changes in the mental health services to be provided.

Answer: See the grid below for DSHS Mental Health Included and Excluded Services for the Outpatient Only Capitation.

Included Services

Outpatient Services	CPT-NASMHPD Codes
Day Treatment	00013, 00015
Group	00038, 00050, 00053, 90849, 90853, 90857, 99411, 99412
Individual	00001, 00002, 00003, 00004, 00005, 00014, 00016, 00017, 00018, 00019, 00020, 00021, 00024, 00037, 00039, 00040, 00041, 00042, 00043, 00044, 00046, 00052, 00054, 90801, 90802, 90804, 90806, 90808, 90810, 90812, 90814, 90816, 90817, 90819, 90845, 90846, 90847, 90875, 90876, 90880, 90882, 90885, 90887, 90889, 96100, 96110, 96115, 96117, 97530, 97532, 97533, 97535, 97537, 99075, 99201, 99202, 99203, 99204, 99205, 99206, 99207, 99208, 99209, 99210, 99211, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99253, 99254, 99261, 99262, 99263, 99274, 99275, 99311, 99312, 99313, 99331, 99332, 99333, 99342, 99347, 99348, 99349, 99350, 99361, 99362, 99371, 99372, 99373, 99401, 99402, 99403, 99404, 99420, 99499, 99737
Medical Management	00006, 00007, 00008, 90782, 90805, 90807, 90809, 90811, 90813, 90815, 90862, 90899, 99070
Peer	00022, 00023
Foreign Language Interpretation	

Excluded Services

Crisis (codes 00009, 00011, 000012); Inpatient Facility; Residential; Medicaid Personal Care; Blended Funding; ECS

33. Issue: About 600 Medicaid-only clients that we case manage for Long Term Care services will be included in auto enrollment.

a. If the client's current doctor is not a participant in the plan: How will the client select a doctor? Will the client have to initiate transfer of their medical records to their new doctor? Can they maintain the care with their old doctor through the opt-out time period, so that if they do decide to disenroll, they will still have a doctor outside the plan? How long will a client be able to continue getting medication refills from their old doctor before having to switch to getting a prescription authorized by the plan's doctor? (These are issues that may be quite confusing for non-English speaking clients).

Answer:

- If a client (whether they have a current provider or not) chooses to enroll in the WMIP plan, the plan will assist the enrollee to select a provider.
- The enrollee will not have to initiate transfer of their medical records to the new provider.
- There is no opt-out time period – the enrollee may choose to disenroll at any time; however, once enrolled in the plan, the enrollee would be required to see a participating provider.
- The client may continue to get refills for medications prescribed by their non-participating provider as long as the prescription has allowable refills. The only exception to this would be any prescribed medications that are not part of the plan formulary.
- As has been mentioned at several meetings, the WMIP contractor, as a Medicaid-funded MCO, will be required to provide materials in whatever format makes them understandable to the enrollee – this includes face-to-face contact to explain the program in the enrollee's primary language.

b. Some clients have in-home Medicaid Personal Care services funded through the RSN. Snohomish County Human Services Department's Division of Long Term Care & Aging case manages these clients, including CARE assessment and SSPS authorization of these services; RSN staff reviews and approves the plan for payment. Will the mental health case management and funding for these Medicaid Personal Care services be part of the outpatient services the plan is responsible for?

Answer: Currently, as in the above table, the Medicaid Personal Care services funded through the RSN are not part of the WMIP rate. Once long term care is incorporated into the WMIP set of benefits, we will reconsider including RSN-funded personal care.

38. Final Contract:

a. What are the final contract terms? How will Exhibit A, the Certification and Assurances, be amended, if at all?

Answer: The final contract terms will be negotiated once the contract has been awarded. The final contract will be shared at the earliest possible time.

b. What are the current rates? On what actuarial studies are they based?

Answer: All Medicaid managed care rates must be produced in an actuarially sound manner in order to be approved by CMS. CMS can override rates submitted by DSHS and their actuaries which would necessitate adjustments to the WMIP/RSN allocations of funding.

c. How will RSN be impacted financially? February 2004 Q&A indicate "we cannot predict how many clients in which category (aged or disabled) will voluntarily enroll in WMIP. Our current estimate is that 7% of the RSN funds will go to WMIP."

Answer: A more current estimate is 5%. See also answer to 18 above.

d. Regarding potential cost shifting between outpatient and inpatient services, what methods, if any, will DSHS use "to guard against cost-shifting in either directions that may include financial incentives or retroactive reconciliation?"

Answer: See answer to 18 above.

40. What are the unintended impacts on consumer direct and indirect services? What are the impacts of integration on clients, services providers/networks and staff? What is being done to mitigate the impacts?

Answer: DSHS is hoping to work with the Snohomish County Advisory Committee to detect any unintended impacts early in the project, and to take early corrective measures to mitigate those if they occur.

42. If this pilot is not successful, what steps are being taken to ensure that a safety net remains to protect Snohomish County adults who receive Medicaid-funded services? How limited will remedies be once implementation occurs? Please also respond to alternative proposals submitted by Snohomish County.

Answer: DSHS' division of the MHD services between the RSN and WMIP contractor was an attempt to leave the mental health infrastructure largely intact.

The proposals received from the community did not respond to the purpose of this project, which is to pilot a system of integrated care across DSHS services. The Snohomish County proposal, which was responded to by Secretary Braddock, focused on providing a medical model only, with mental health services to be incorporated in several years. However, providers have stated they do not want to see enrollees for medical services only when mental health and chemical dependency issues are not being addressed. An integrated system seems the best method of increasing access to care for these high risk clients.

Newly released studies of ER utilization for DSHS clients reinforce this approach, as many of the ER claims for Medicaid clients are related to mental health or substance abuse diagnoses. (See link to RDA study from WMIP website.)

46. How will proposal impact Snohomish County? How will changes in Snohomish County impact the other four counties in the RSN? What will be the region-wide impacts?

Answer: The positive impact will be an increase in access to primary and preventive health services for DSHS clients. WMIP implementation should not cause changes in the other counties in the region.

47. Has the "additional workgroup to focus on the impact to the remaining system" referred to in the February 2004 Q&A "best be developed by staff external to the WMIP project" been formed? What are its purpose, composition, and structure?

Answer: The Community Advisory Committee will be considering whether this is one of its purposes, or whether an additional group needs to be formed to address issues outside of the immediate WMIP project.

48. Does the financing of the project lead to substantial degradation of services and service capacity for seriously mentally ill adults in Snohomish County?

Answer: No. There should not be a change to service capacity for seriously mentally ill adults, except that they will have access to 24 hour medical advice and a guaranteed medical home through the managed care plan.

49. How does WMIP reduce duplication?

Answer: As stated in a previous Q&A release, there is no reason to believe that there will be any more duplication of administrative functions for any of the services covered by the WMIP. Because a single entity will be coordinating medical and mental health services, the only potential administrative changes would be that mental health providers would bill the plan, not the RSN or the APN.

63. Please respond to the White Paper prepared by Barbara Mauer for the North Sound Mental Health Administration.

Response to Key Findings from the Mauer/Jarvis White Paper
Prepared by David Mancuso, Research and Data Analysis Division, DSHS

Medical Cost Offsets. The White Paper cites a preliminary literature review conducted by DSHS staff which states that "…for individuals with serious mental illness mental health treatment may not create medical cost offsets…"[1] This is used to justify an assumption that "Medicaid enrollees with low to moderate behavioral health risks and complexity … should be the target for expanding mental health services in the WMIP project." This assumption is not part of the WMIP planning that has occurred to date. In fact, an actual Cost Offset Study conducted by DSHS on Washington State Medicaid clients found that there were large medical

[1] Anderson N and Estee S. Medical Cost Offsets Associated with Mental Health Care: A Brief Review. DSHS, December 2002.

cost offsets when mental health services were provided to DSHS clients with serious mental illness, including psychosis and bipolar disorders.[2] DSHS planning for the WMIP project has centered on clients with serious mental illnesses.

WMIP Revenue and Expense Transfer Implications. The White Paper presents estimates of the fiscal impact of the WMIP project on the NorthSound RSN using three hypothetical scenarios; looking at the potential characteristics of WMIP enrollees. There are several problems with these estimates. First, the White Paper estimates were developed from earlier concepts that do not reflect the current WMIP design which includes outpatient services only. Second, the White Paper uses FY 2003 rates to estimate the cost of services provided to WMIP enrollees, but uses FY 2005 rates to estimate the revenue associated with WMIP enrollees. The White Paper should have used FY 2005 estimates for both costs and revenues.

Third – and most critically – the White Paper authors confuse "expenditures per eligible client" with "expenditures per served client" in their calculations. The White Paper applies "expenditures per eligible client" to the number of clients served to estimate the service costs that will be transferred from the RSN to the WMIP vendor. Instead, the authors should have applied "expenditures per served client" to the number of clients served to estimate the service costs transferred to the WMIP vendor. As a result, the White Paper underestimates the cost of service obligations that will be transferred from the RSN to the WMIP vendor, and overestimates the fiscal impact of WMIP on the RSN.

In fact, when the calculations are performed correctly there is essentially no financial impact on the RSN in the White Paper's 2nd and 3rd scenarios. This is demonstrated in the attached tables. Scenario 3 assumes that there is no selection bias among enrollees who will use the WMIP program. The attached table shows that when costs are correctly calculated, there is a net transfer of resources to the RSN of $763. That is, the service costs that will be paid by the WMIP vendor exceed the revenues transferred from the RSN to the vendor by $763.[3]

Scenario 2 assumes that there is substantial selection bias in WMIP enrollment across Medical Assistance eligibility groups (in favor of aged enrollees), but that there is no selection bias in the propensity to use RSN services within the aged, blind, disabled, and presumptively disabled eligibility groups. That is, scenario 2 assumes that aged clients are more likely to enroll in WMIP than disabled clients, but the clients who enroll in WMIP are as likely to use mental health services as non-WMIP clients in the same medical assistance eligibility group.

The attached table shows that when costs are correctly calculated for Scenario 2, there is a net transfer of resources from the RSN of $845.[4] Scenario 2 has no significant financial impact on the RSN because the capitation rates are already stratified (risk adjusted) by aged, blind, and disabled eligibility status, and this scenario assumes no selection bias within these eligibility groups.

The 1st scenario in the White Paper assumes that none of the disabled clients served by the RSN will choose to enroll in WMIP. While this level of disenrollment is unlikely, DSHS is aware of

[2] Mancuso D and Estee S. Washington State Mental Health Services: Cost Offsets and Client Outcomes. DSHS, December 2003.
[3] The net transfer is not exactly zero due to rounding (that is, enrollees are rounded to whole persons).
[4] The net transfer is not exactly zero due to rounding.

the potential for adverse selection and disenrollment. The Department has agreed that it will be carefully monitoring WMIP enrollment, and will consider incorporating additional risk-adjustment into the mental health component of the WMIP capitation if there is shown to be substantial adverse selection from the perspective of either the RSN or the WMIP vendor.

Combined Premium Transfer and Benefit Mismatch. As discussed above, the conclusion discussed in the White Paper – that there is a mismatch between the funding transferred from the RSN to the WMIP vendor and the cost to deliver the service benefit – is based on fundamentally incorrect estimates about the financial impact of the WMIP project on the RSN. The corrected estimates show essentially no premium transfer under Scenarios 2 and 3.

Adjustments for Inpatient Dollars and Risk Staying with the NSRSN. DSHS is well aware of the potential for shifting clients into more expensive, higher intensity services. The Department will be closely monitoring outpatient and inpatient mental health service utilization in Snohomish County to identify any cost shifting that may occur. Any cost-shifting that is identified will be highlighted in evaluation reports.

Corrected Scenario 3: No Selection Bias in Enrollment

Shift of captitation rate from RSN to WMIP contractor:

	WMIP Target Enrollees	MHD PMPM	Average Eligible Months	Annual Revenue
Snohomish Aged	2,450	$6.92	12	$203,448
Snohomish Blind	10	$55.89	12	$6,707
Snohmish Disabled	2,953	$55.89	12	$1,980,518
Snoh. Presumptive SSI	587	$55.89	12	$393,689
Total	6,000			$2,584,362

Shift of service costs from RSN to WMIP contractor:

	NSRSN Clients	Per Served Client Per Month	Average Eligible Months	NSRSN Costs
Snohomish Aged	232	$73.09	12	$203,470
Snohomish Blind	2	$298.08	12	$7,154
Snohmish Disabled	1,576	$104.74	12	$1,980,819
Snoh. Presumptive SSI	551	$59.54	12	$393,682
Total	2,361			$2,585,125

Difference: $763

Corrected Scenario 2: Selection Bias Towards Aged Clients, but No Selection Bias Within Groups

Shift of captitation rate from RSN to WMIP contractor:

WMIP	Target Enrollees	MHD PMPM	Average Eligible Months	Annual Revenue
Snohomish Aged	3,950	$6.92	12	$328,008
Snohomish Blind	16	$55.89	12	$10,731
Snohmish Disabled	1,976	$55.89	12	$1,325,264
Snoh. Presumptive SSI	58	$55.89	12	$38,899
Total	6,000			$1,702,902

Shift of service costs from RSN to WMIP contractor:

	NSRSN Clients	Per Served Client Per Month	Average Eligible Months	NSRSN Costs
Snohomish Aged	374	$73.09	12	$328,008
Snohomish Blind	3	$298.08	12	$10,731
Snohmish Disabled	1,054	$104.74	12	$1,324,736
Snoh. Presumptive SSI	54	$59.54	12	$38,582
Total	1,485			$1,702,057

Difference: -$845

Corrected Scenario 1: Extreme Selection Bias

Shift of captitation rate from RSN to WMIP contractor:

	WMIP Target Enrollees	MHD PMPM	Average Eligible Months	Annual Revenue
Snohomish Aged	3,950	$6.92	12	$328,008
Snohomish Blind	16	$55.89	12	$10,731
Snohmish Disabled	1,976	$55.89	12	$1,325,264
Snoh. Presumptive SSI	58	$55.89	12	$38,899
Total	6,000			$1,702,902

Shift of service costs from RSN to WMIP contractor:

	NSRSN Clients	Per Served Client Per Month	Average Eligible Months	NSRSN Costs
Snohomish Aged	374	$73.09	12	$328,008
Snohomish Blind	3	$298.08	12	$10,731
Snohmish Disabled	0	$104.74	12	$0
Snoh. Presumptive SSI	0	$59.54	12	$0
Total	377			$338,739

Difference: -$1,364,163